• APRIL ISSUE | • 2007

NCA

OFFICE OF INTEGRATION NEWSLETTER

SERVING AS THE VOICE OF THE OFFICE OF INTEGRATION

in·te·gra·tion | in-ti-**grey**-sh*uh* n |

the combining and coordinating of separate parts or elements into a unified whole

Admiral Robinson Earns Second Star

Commander of National Naval Medical Center (NNMC), Rear Admiral Adam Robinson, Jr., has been selected for his second star, promoting him to Rear Admiral upper half. The man known for his remarkable candor has been a very vocal, public advocate for the integration of Walter Reed Army Medical Center (WRAMC) and National Naval Medical Center (NNMC).

Beginning in August 2005 at a town hall meeting attended by senior leaders from both medical centers, Admiral Robinson, in concert with Major General Farmer, then commander of Walter Reed, outlined his vision for integration.

In the wake of the Base Realignment and Closure (BRAC) recommendations becoming law, Admiral Robinson silenced many critics, Navy and Army, alike, by challenging them to choose a side— to support integration or to not support integration! In a career defining moment and during what was perceived by many to be a potential political landmine, he chose to publicly support integration. Why, you ask? Robinson supported it because it was the "right thing to do".

> *"I am committed… to constructing new traditions in order to build the care system that our patients deserve and our nation demands."*

Close to two years later, the soon to be two-star admiral reaffirmed his commitment to the integration of the medical centers in the April 5th edition of his Commander's Column, a weekly op-ed column published in The Journal, National Naval Medical Center's command newspaper. He writes: "I am committed… to constructing new traditions in order to build the care system that our patients deserve and our nation demands." ■

INSIDE THIS ISSUE:

LETTER FROM THE EDITOR

Dear Readers,

With the rising and mounting costs of healthcare, change remains an irrefutable constant within the healthcare industry. The Military Health System (MHS) is no exception to this reality.

Since 2001, the cost of military health care has doubled from $19 billion to $38 billion, according to the Department of Defense (DoD). In an attempt to ensure that future funding remains available to sustain war readiness, Congress passed the 2005 Base Realignment and Closure (BRAC) law.

The passing of the 2005 BRAC law by Congress, designed, in part, to transform the MHS by achieving economies of scale between Walter Reed Army and National Naval Medical Centers, became a clear indicator as to how prevalent the need for change was.

During these precarious times, the senior leaders of these historic institutions, along with their colleagues from the Air Force and Uniformed Services University, are working tirelessly to contend with in a concerted effort how best to effectively move forward together with this mandate for change.

Consequently, the charge and challenge for the Office of Integration Newsletter is to ensure that as the National Capital Area flag officers work relentlessly to achieve a collective approach for integration that we deliver to you accurate news regarding these efforts. This is a charge we take very seriously.

Therefore, as integration develops and change appears constant, you can depend on this newsletter to serve as a medium committed to providing you with both relevant and pertinent information. This month we share with an overview on how integration is evolving.

Best Wishes,

The Functional Phase of Cultural Integration

By : Barbara J. Flint, PhD, Technical Writer, Office of Integration

Integration is a frontier destination -- a place that has not yet been seen and a state that has not yet been achieved. The Base Realignment and Closure (BRAC) Commission set this destination. As one senior military leader noted: "Inherent in BRAC 2005 MHS actions is the integration of Medical Treatment Facilities (MTFs) such that they function as an Integrated Delivery System" (IDS). When the BRAC process reaches fruition there will be healthcare personnel from the Army, Navy, Air Force and Uniformed Services University (USU) jointly taking care of our patients and ensuring that the best training opportunities are available in the Military Healthcare System (MHS) within the National Capital Area (NCA). This IDS will be characterized by a central structure which will streamline services and eliminate redundancy.

BRAC law mandates an integrated healthcare system. Joint Tri-Service efforts will be required across the system and services and by 2011, at the latest, will replace today's voluntary and cooperative efforts. How will this be accomplished? Creating an IDS is an extremely tall order. In BRAC directives, the IDS is fairly well defined but there are, perhaps, only a few very vague indicators of how it is to be developed. The physical components of BRAC - - building a new hospital or expanding and rehabbing an existing facility could fairly easily be accomplished. But, what about integration - - the relocating and the combining of services and functions? How will three Services and the University each with distinct traditions, distinct cultures and distinct paradigms be unified to function as one?

"Integration" as dictated by BRAC is decidedly outside the usual experience of the MHS. The successful creation of an IDS requires more than a legal fiat. Some "blind faith" and "true believers" are very necessary to achieve the changes in behavior, in systems, and in perspectives that an integrated system necessitates. This review will examine the integration process from its beginnings in August 2005. It will highlight the context for and the methods used to generate "unifying concepts and commonalities." Hopefully, this will provide some insights regarding "blind faith" and "true believers" and the integration vision.

Sharing the Vision:
It is a well-known tale that a major, if not the first, step toward functional integration was the vision statement issued by the Flags -- Maj. Gen. Kenneth L. Farmer Jr. and Rear Adm. Adam M. Robinson Jr. In August 2005, these leaders delivered a "Shared Vision," a united message stating that, henceforth, military health care in the National Capital Area would no longer be operated by each service in an independent fashion. Over time, this vision statement was revised to greater specificity and the Flag team supporting the statement was expanded to include Dr. Charles Rice, President of Uniformed Services University of the Health Sciences and the Air Force Brig. Gen. Thomas Travis, then Commander of the 79th Medical Wing headquartered at Andrews Air Force Base. The Army Flag and Air Force Flag were both changed in August 2006, but no changes to the vision statement have been made since its approval in June 2006.

The Vision:
"We envision and are committed to one integrated health system that leverages the assets of all DoD health care treatment facilities in the National Capital Area (NCA). The tri-service Walter Reed National Military Medical Center at Bethesda will be a worldwide military referral center and together with the Uniformed Services University of the Health Sciences (USUHS) will represent the core of this integrated health system. All tri-service facilities in the NCA and USUHS will serve as a premier academic medical system focused on delivering the highest quality care, distinguished health professional education, and exemplary clinical and translational research."

MG Farmer stressed that this vision preserved the 97-year legacy of Walter Reed's commitment to excellence in patient care, academic education and research, while integrating its services with those of other defense health care facilities and Uniformed Services University in the area. In June 2006, he reiterated his May 13, 2005 assertion that integration "is the right thing to do" with an added caveat: "this is the right thing to do, if we do it right . . ." His statement that integration is the "right thing to do" is still echoed in support of actions toward functional integration by leaders throughout the NCA.

The Vision stressed what could be and what should be. The Flags, especially General Farmer and Admiral Robinson, appealed to shared values. Buy-in by key integration leaders was very successful and at every opportunity leaders joined the Flags in espousing the vision. Integration leaders shared the vision with service members and civilians hoping to imbue them with the vision as well as to adapt the vision to their constituent's needs. The Flags would add specificity to the vision with the creation, in June 2006, of the Four Overarching Objectives for Functional Integration: **(1)** Collective Decision Making, **(2)** Clinical Integration, **(3)** Selection and Role of Leaders, and **(4)** Integrated MHS in the NCA.

Clarifying Meaning:
If the vision was to be embraced and firm commitment gained for integration, then it was necessary for everyone to be speaking the same language.

Continued on page 4

In September 2005, the NCA BRAC Steering Group focused on clarifying and making the key concepts operational. Integration, they explained, is the final product – a jointly operated medical center that is in place by the 15 Sept 2011 BRAC deadline. Functional integration, on the other hand, refers to "all of the intermediate steps " that must take place before that date. These operational definitions are provided, reinforced and clarified by integration leaders at all venues of information exchange about integration. As COL Thomas Fitzpatrick, Director of Office of Integration, explained: With BRAC, "We talk about buildings, but that has nothing to do with integration. Integration is how people can get together and start working together for common goals," he said. Integration was the destination – the common goal.

Confronting Culture:
After clearly addressing the conceptual issue, a next step in insuring the success of the Vision was to recognize and address perceptual barriers to the desired end state. Perceptions defined and reinforced by culture and traditions, if not specifically addressed, were likely to be a major impediment to integration. Each individual and each service had its own world view, its self-organizing patterns, and its re-enforcing systems - - its paradigm. The concept of an IDS did not easily fit within these established paradigms.

From the outset, the reality of perceptual difference was recognized and discussed across the Service at all levels. Various leaders noted that the biggest challenge was culture. The facilities "all have their own culture, whether you're at Malcolm Grow, Bethesda or Walter Reed. It can be a major impediment," said one senior official. Even though there were repeated references to "culture," cases could not be found of service specifics examples or meanings of "culture." Culture embodies the background and traditions that shape each institution. CAPT Lou Damiano, WRAMC Deputy Commander for Integration, summed up the import of cultural differences. The way the commands are organized are different. "Trying to meld groups together creates a fair amount of anxiety among the staff at both Bethesda and Walter Reed. That's primarily based on the fear of the unknown," he said.

In addition to fear of the unknown, many fear that "they are going to lose their identify." Navy Captain Richard Stolz, from the Bureau of Medicine and Surgery, noted that in the NCA all of the military health-care facilities "have a rich history of at least 60 years or more . . ." Many felt that integration could force them to give up their history. COL Fitzpatrick observed, "The Army people are worried that all the projects that they've worked on for years, the training programs and the way we do things, are going to be lost. "Bethesda has the same concerns," he added. "Bethesda is concerned that the bigger Walter Reed is going to come over and just stamp out and erase their identity -- that's not our goal." COL Nadja West, The Deputy Commander for Integration at NNMC, stated "I don't think we should lose our identities and I don't think we should ... become some blended 'purple thing'. But, as the process gained momentum and progress was evident, decreasing emphasis was placed on the "culture problem" and considerably more stress was placed on the importance of commonality and functionality.

Seeking Common Ground:
The leaders readily recognized that adherence to existing paradigms could undermine the success of integration efforts. Robinson stressed that although "'culture' is paramount, for all the services at every level 'cultural jumps' will have to be made." Delineating shared values and common functions as well as creating processes that required crossed-service involvement were the keys to avoiding resistance and making those jumps.

Insuring the quality of care provided to patients became an easily identifiable commonality for all of the services. CAPT Damiano said the patients always come first at both institutions. So, staff from each institution "shares a similar vision for the future of the new Walter Reed National Military Medical Center", he stressed. Navy Captain Miguel Cubano, Office of Integration's Deputy Director, stated that melding cultures to create a world-class medical facility would happen, . . . Why are we doing it? For the patient," Cubano said. "Nothing makes sense if we don't do it for the patient." USU's President Rice stressed the unifying role of education in preparing medical staff in the same manner or processes. COL Greg Argyros, Chief of WRAMC's Department of Medicine, and others physicians noted that finding common ground and performing functions or processes the same way would hasten integration.

To create an IDS, leaders had to find ways to break through traditional, cultural-specific barriers. The consensus was, "The way that we chose to move forward with integration is to focus not so much on who we are, but what we do." All the services agreed that the one common thing "is that we take care of patients, we take care of our warriors and their families. If you keep your eye on that, the other peripheral differences of cultures will fall by the wayside."

It was generally recognized by the services, that organization structures, information technology infrastructures and many administrative policies were quite different. However, it was understood that these differences could be resolved -- "they are challenges but they are not insurmountable." The outcome and success of integration was dependent on working together. As RDML Robinson opined, "We can do anything as a cohesive team. Our services, our patients and our Nation depend on us. We will not fail them." A cohesive Tri-Service team would honor the rich heritage and culture that exists in all Services –" no Service will lose their culture but all will gain."

The presence of Tri-Service support in the efforts to make the "cultural jumps" validate the claim that functional integration is on a strong, steady course. "Functional integration is moving from 'us vs. them' to us. It means we become us." ■

Change Management and Cultural Synergy: A Positive View Toward Change

By: Howard Demmings, Sr.

Cross-cultural Service issues are among the most central and persistent factors that will influence management and business activity during this integration. As we progress toward NCA integration, we face a long list of challenges. For example, integrating organizational cultures means understanding (1) differences in communication patterns and styles, (2) preferences for leadership approaches, (3) different principles of hierarchy, (4) organizational structures, and (4) different methods of decision making. The list could go on, but I think you get the message.

Fundamentally, what is the source of these cultural differences, where do they come from, and how might they be changed? To address these questions consider the following. The relationship between:

(1) organizational heritage,
(2) underlying dynamics of cross-cultural management, and
(3) cross-cultural Service issues.

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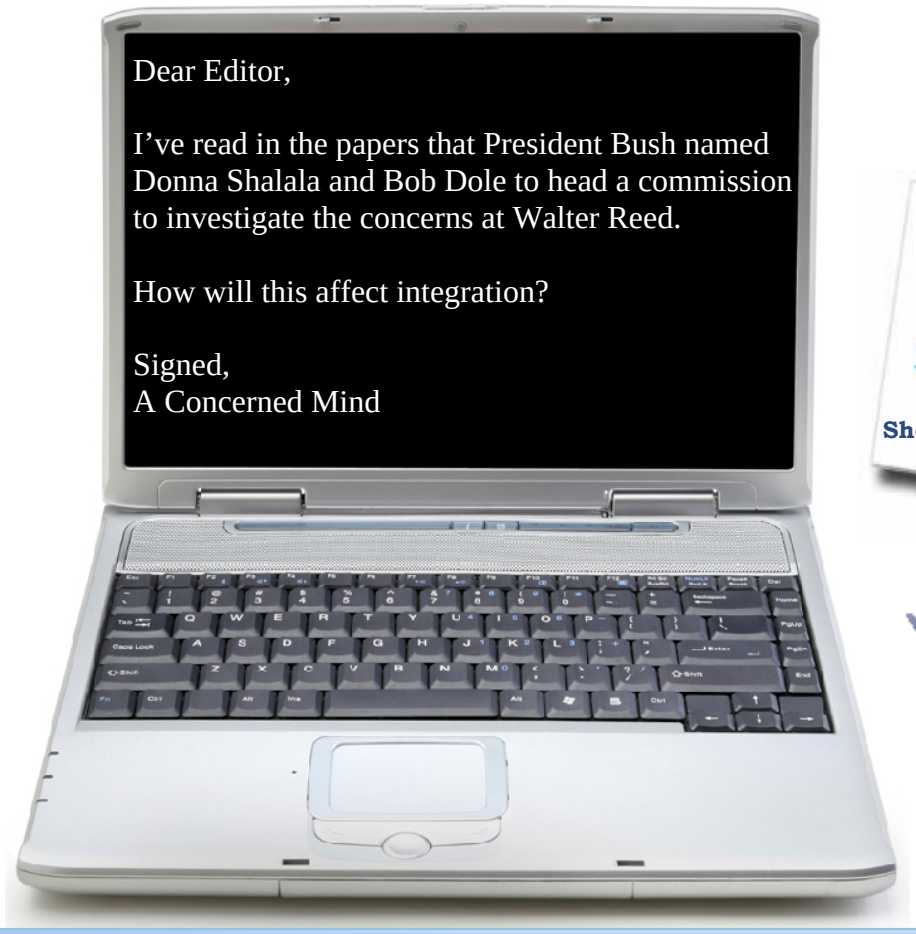
I recently read a book called "Teaching the Elephant to Dance", by Dr. James A. Belasco, PhD., which compared organizations to elephants. Both are large, ponderous organisms that learn through conditioning. Moreover, once conditioned, both tend to keep operating in the same way over time. Baby circus elephants are leashed to a pole and led around it. As they grow, they become accustomed to following the same path around the pole, even through they could easily break the leash if they tried. By the time the leash is removed, the elephant has become thoroughly conditioned— while it could diverge from its course around the pole at any time, it keeps on trudging. Many healthcare organizations find themselves in a similar position. Yet, we just cannot afford to keep plodding around the same old pole, faced with budgetary constraints, staggering personnel shortages, integration issues, and tough regulatory mandates.

Shackled like powerful elephants, some organizations rob themselves of the ingenuity required to meet new challenges. Instead of concentrating on long-term solutions, they drudge into the trap of re-engineering, re-organizing, re-structuring and focusing on short-terms fixes. This results in a culture of holding onto 'the way we've always done it' and 'this is the way we do things around here'! This is a warning sign for any organization.

Understanding culture helps to "grease the wheels" of change. Change moves individuals and organizations from one place to another. However, what is the best direction? Which approach should be followed, why, and when? The answers lie in an organization's vision, strategies and planning for implementation.

Organizational change also involves improving processes. However, processes are envisioned and executed by people. Change is most successful when people's minds, emotions and actions are engaged. Change leaders must tap the potential of individuals, teams and organizations to facilitate change and acquire "Buy-In". It is not my organization, nor is it theirs, but it is ours! Our opportunity, then, is to embrace a new and different culture because the best "culture for change" is one of trust, understanding and cooperation. ■

LETTER TO THE EDITOR



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To... A Concerned Mind

Cc...

Subject:

Dear "A Concerned Mind",

It is true. President George W. Bush has named former Health and Human Services Secretary Donna Shalala and former Senator Bob Dole as Co-Chairs of the nine-member commission who is responsible for investigating the concerns raised in the media about the care provided to our wounded warriors at Walter Reed.

What we know is that this commission isn't just looking at Walter Reed Army Medical Center, but at all military and veteran's hospitals. The committee has been charged to report their findings and recommendations to the President by late July of this year. They will be basing their findings upon multiple hearings and site visits to the various military and VA hospitals throughout the country.

While we can't forecast what will occur as a result of this commission's investigation, what we're most certain of is that what affects Walter Reed Army Medical Center will most likely affect the integration efforts.

We can't control those outcomes, but we can control how we respond. We are committed to keeping you informed of those events that affect integration as a whole. So, please stay tuned.

Signed,
Newsletter Editor

Are You Acronym Crazy?

Don't worry, we want to provide some clarity.

In a culture where acronyms are commonly used, new events such as the Base Realignment and Closure (BRAC) recommendations being made law by Congress, brings into existence more acronyms that typically make communicating in a culture like ours a little crazy.

Here we try to make sense of it all for you. Brace yourself, because a few of these may surprise you. This month you'll find meanings to some commonly used acronyms. ■

NAVFAC– Naval Facilities Engineering Command
Definition:
Headquartered at the Washington Navy Yard, this command is comprised of engineers, architects, contract specialists, and other professionals who provides facilities engineering and acquisition for the Navy and Marines Corps, Unified Commanders, and Department of Defense agencies through six business lines: 1.) Capital Improvements, 2.) Environmental, 3.) Real Estate, 4.) Public Words, 5.) Base Development, and 6.) Contingency Engineering

NEPA– National Environmental Policy Act
Definition:
This act which was signed into law on January 1, 1970 to establish national environmental policy and goals for the protection, maintenance, and enhancement of the environment, and it provides a process for implementing these goals within the federal agencies.

NNMC– National Naval Medical Center
Definition:
The naval hospital located in Bethesda, Maryland, which serves as the flagship of Navy Medicine.

O&M– Operating & Maintenance
Definition:
A term to describe routine and emergency operations and maintenance of government infrastructures and commands that maintain readiness.

OI– Office of Integration
Definition:
A senior staff office created by former Walter Reed Army Medical Center Commander, Major General Farmer, to support integration activities within the National Capital Area Military Health System.

OMB– Office of Management and Budget
Definition:
This office's primary mission is to assist the US President in overseeing the preparation of the federal budget and to supervise its administration in Executive Branch agencies.

Army OTSG– Office of the Surgeons General
Definition:
This office that supports the Army Surgeon's General in protecting and sustaining a healthy and medically protected force, deploying a trained and equipped medical force that supports Army and DoD Forces world-wide.

PFD– Program for Design
Definition:
A room-by-room listing of the architectural requirements for a specified operational facility, which outlines the space requirements needed for architect blueprints to be designed for personnel.

QDR– Quadrennial Defense Review
Definition:
An annual report that serves as a part of the continuum of transformation in the Department of Defense (DoD). Its purpose is to help shape the process of change to provide the United States with strong, sound, and effective war fighting capabilities in the decades ahead.

RUMOR CONTROL CORRECTION:

ODPs ***do*** assist with building bridges between people to create systemic change.

ROMO– Range and Military Operations
Definition:
Describes the military operations across the Services, which extend from war to military operations across the Services that are other than war.

RUMOR CONTROL: SO TRUE OR SO FALSE

SO TRUE

Admiral Adam Robinson, Jr., commander of NNMC, has been selected for his 2nd star

SO FALSE

Integration of the Medical Centers is at a standstill

SO TRUE

The Office of Integration and the Deputy Commanders for Integration are working to establish a collective approach to achieving integration

SO FALSE

Walter Reed is CLOSING

SO TRUE

WRAMC and NNMC are merging to create Walter Reed National Military Medical Center at Bethesda

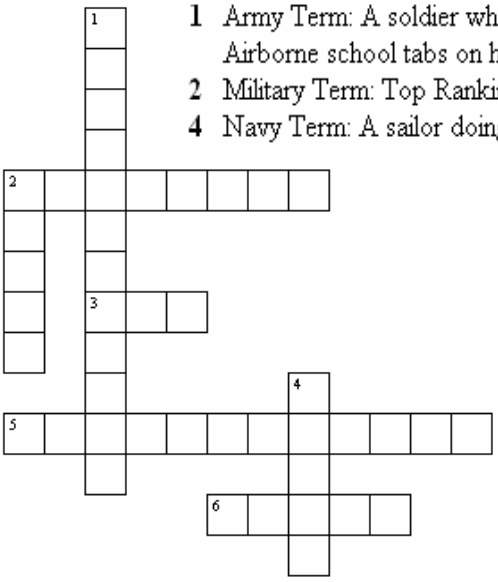
Our Mission:

Force Health Protection

To meet and adapt to the evolving health care needs of our military force, our mission, as established by the Department of Defense, is to use preventive health techniques and emerging technologies in environmental surveillance and combat medicine to protect all service members before, during, and after deployment.

Force Health Protection is designed to improve the health of service members, prepare them for deployment, prevent casualties, and promptly treat injuries or illnesses that do occur, as well as care for their family members, and retirees and their families, who have served this great nation.

TRI-SERVICE CROSSWORD PUZZLE



DOWN

1 Army Term: A soldier who wears the Special Forces pipeline, Ranger school, and Airborne school tabs on his uniform
2 Military Term: Top Ranking Officers
4 Navy Term: A sailor doing duty in a ship's galley

ACROSS

2 Navy Term: Interior structural divider of ship
3 Air Force Term: The F-100 Fighter
5 Military Term: Do Some Push-Ups
6 Marine Term: Nickname for Gunnery Sergeant

ANSWERS FROM LAST MONTH:

ACROSS	DOWN
1 Jump Boots	2 o'Dark Hundred
3 Rank	4 Cherry
6 Commodore	5 PCS
7 Aye	

National Capital Area Military Health System

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THE FUTURE OF THE NCA MHS

Our Vision

We envision and are committed to *one* integrated health system which leverages the assets of all DoD health care treatment facilities in the National Capital Area.

The Tri-Service Walter Reed National Military Medical Center at Bethesda will be a world-wide military referral center and together with the Uniformed Services University of the Health Sciences (USU), will represent the core of this integrated health system.

All Tri-Service facilities in the NCA and the USU will serve as a premier academic medical system focused on delivering the highest quality care, distinguished health professional education, and exemplary clinical and translational research.